

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157541	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2016
NAME OF PROVIDER OR SUPPLIER ALLPOINTS HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9801 PRAIRIE AVE HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	<p>INITIAL COMMENTS</p> <p>This was a Federal home health complaint investigation survey.</p> <p>Survey Date: 7/5/16 and 7/6/16</p> <p>Facility ID: 003142</p> <p>Medicaid Number: 200387660</p> <p>Facility unduplicated census for the last 12 months: 63</p> <p>Clinical Records Reviewed without home visit: 3 Clinical Records Reviewed with home visit: 1 Total Clinical Records Reviewed: 4</p> <p>Complaint number's IN00199246 and IN00201274 were found to be unsubstantiated.</p>	G 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.